



Investing in Public Health: Barriers and Possible Solutions

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Introduction

Public expenditure on prevention in OECD countries seldom exceeds 10% of total public expenditure on health. In New Zealand, expenditure on public health is tiny compared with total spending on health. Ministry of Health spending on prevention and public health is only 5% of total health and health-related expenditure.

Many public health interventions have been shown to save money, and some have cost-effectiveness ratios better than or equivalent to health care interventions. Some examples include:[1]

- Tobacco control programmes
- Immunisation (for example childhood immunisation for diphtheria, tetanus, pertussis, rotavirus)
- Cardiovascular disease prevention (population preventive strategies leading to population risk factor changes)
- Some workplace health promotion programmes

In 2001, a report on the long-term trends affecting the health service in England was commissioned by Her Majesty's (HM) Treasury. This report, the Wanless Report, modelled three scenarios, and found that the one which required considerable investment in public health was not only the least expensive scenario modelled, but also delivered the best health outcomes.[2]

In Australia, the National Preventative Health Taskforce produced a report outlining the case for improving the prevention of illness and the promotion of health in Australia.[3] The Taskforce took an evidence-based approach which found that 'effective prevention brings significant benefits to society as a whole, including improved economic performance and productivity'.

An American report 'Prevention for a Healthier America' found that investment in proven community-based disease prevention programmes would be cost-saving; 'Within 5 years, the return on investment could rise to 5.6 for every \$1 invested and rise to 6.2 within 10 to 20 years. This return on investment represents medical cost savings only and does not include the significant gains that could be achieved in worker productivity, reduced absenteeism at work and school, and enhanced quality of life'.[4]

Similarly, the Canadian 'Healthy People, Healthy Performance, Healthy Profits' report found that 'shifting attention to strategic investments in the socioeconomic determinants of health promises to deliver not only improvements in health outcomes, but also cost-savings and economic benefits'.[5]

From 2012, improving public health and reducing inequalities became the responsibility of local authorities, rather than the National Health Service (NHS) in England. Directors of Public Health have had to advocate for public health in a new environment, where there is some ring-fencing of public health funding but where politicians were unfamiliar with public health.[6]

The strategies the Directors of Public Health used in order to make the case for investment in public health have included economic arguments and evidence of impact, especially over the short- and medium-term.[6]

Methods

In this study, published papers, reviews and reports on the cost-effectiveness of public health interventions and barriers to investment in public health were reviewed. Potential ways to address the barriers and to increase investment in public health were developed, using examples of successful strategies where possible.

Acknowledgements

The support of the Wayne Francis Charitable Trust is acknowledged.

Results

There is evidence to support investment in public health. Despite this, there are barriers to investing in public health.[1]

- The first barrier leading to inadequate resourcing of public health is the expectation that public health interventions should save money. This may lead to public health interventions being required to meet a higher standard of economic effectiveness than health care services.
- The second barrier is the belief that, in the long run, prevention costs more than other health spending. Allocating resources to public health strategies may be deemed a poor investment, if people will live longer and incur extra health sector costs later. This aligns with the hypothesis that improvements in health will lead to an 'expansion of morbidity' with an increasing percentage of life-expectancy affected by ill health.
- The third barrier is the time frame for public health interventions. Some public health interventions may not produce results for many years. This disadvantages public health interventions because most decision-makers operate on a much shorter time frame. Short electoral cycles of 3–5 years may not be long enough for elected representatives to see the results of a public health intervention.
- The fourth barrier is the 'identifiable victim effect'. If health resources are scarce, many people would prefer to relieve the suffering of an identified individual than to fund an intervention which does not address current ill health, even if that intervention would improve the health of a far greater number of people.
- The fifth barrier is the influence of interest groups. These include health consumer and patient organisations, which may tend to focus on health care and treatment services rather than public health, and industry interest groups, such as the tobacco and alcohol industries, which can be threatened by public health initiatives.
- The sixth barrier is that evidence is not the only driver of policy and funding decisions.

Conclusions

Possible ways to address these barriers to investment in public health include:

- Advocating for equal economic assessment of public health interventions (the bar should not be set higher for public health compared with other health interventions; public health interventions should not have to be cost saving but cost-effective)
- Refuting the belief that prevention invariably costs more (compression of morbidity)
- Highlighting the potential for investment now to provide greater returns later
- Personalising the benefits of public health interventions (potential for social marketing)
- Addressing non-evidence-based drivers of funding and policy (including the influence of interest groups). Enhancing communication between researchers and policy-makers.

References

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